Ontario

Premier's Council on
Health Strategy

FROM VISION TO ACTION

REPORT OF THE HEALTH CARE SYSTEM COMMITTEE

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Hon. David Peterson
Premier of Ontario
Queen's Park
Toronto, Ontario

Dear Premier Peterson:

An integral part of the mandate of the Premier's Council on Health Strategy is to provide clear, unbiased advice to government on how we might achieve a healthier Ontario. On behalf of the Council, the Health Care System Committee is pleased to deliver our first report on strategic directions for the health care system in Ontario.

The directions and recommendations set out in this report are designed to complement and be consistent with the work currently undertaken by the other committees of the Council.

The Health Care System Committee set out to develop a strategic plan for the health care system within the context of the definition of health put forward by the World Health Organization and *A Vision of Health for Ontario* developed by Council. Developing this plan has required balancing important values for Ontarians, such as access, quality, choice, dignity, and cost-effectiveness in health care.

Our objective is to build on the best of the system we have today and to make it better. The guiding principle is that resources are not limitless. We must strive to make the most effective use of the resources available to us.

It became clear to us early in the process that change is inevitable. Equally clear is that there is never an ideal time for change. These two conclusions may appear irreconcilable, but we also arrived at third reality: if we don't begin to plan and manage change now, change will manage us, occuring in an undirected, uncoordinated manner. The risks this scenario presents far outweigh the risks of initiating and managing our own process of change.

Our report may not be seen to be original. It was, however, agreed on at the outset, not to devote our energies to "re-inventing the wheel", but rather to build on the fine research and advice that has already been made available to the Premier's Council. Through this report, our goal is to facilitate action so we can begin to implement meaningful changes to the health care system.

This goal is reflected in the title of our report, "From Vision to Action". The solutions and recommendations we put forward may not be perfect. They may not address every detailed facet of the problems facing our health care system, and they may not please every sector of the system.

There is, however, no one perfect solution. And there are no magic wands to make things change overnight. By starting now, we are seeking a shift in attitudes, organization, procedures, and results which hopefully will be complete by the year 2000. The question may be asked: Is this enough time? The challenges will be great, but if ten years was enough time to put a man on the moon, then it seems reasonable that we can address the issues confronting our health care system within the same timeframe.

Success will require cooperation. The public, health professionals, and the government must work together to maintain the integrity of our present health care system and to protect the principles on which Medicare was founded. We and our future generations who depend on the health care system deserve no less.

Yours very truly,

Roy Aitken, Chairman

Hugh Scully, M.D.

John Carter

Sr. Alice McEvoy

Eleanor Ross

Health is the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs; and, on the other hand, to change or cope with the environment. Health is therefore seen as a resource for every day life, not the objective of living; it is a positive concept emphasizing social and personal resources, as well as physical capacity.

(World Health Organization)

<u>A Vision of Health</u>

We see an Ontario in which people live longer in good health, and disease and disability are progressively reduced. We see people empowered to realize their full health potential through a safe, non-violent environment, adequate income, housing, food and education, and a valued role to play in family, work and the community. We see people having equitable access to affordable and appropriate health services regardless of geography, income, age, gender or cultural background. Finally, we see everyone working together to achieve better health for all.

<u>Goals</u>

1. ***Shift the emphasis to health promotion and disease prevention.***
2. ***Foster strong and supportive families and communities.***
3. ***Ensure a safe, high quality physical environment.***
4. ***Increase the number of years of good health for the citizens of Ontario by reducing illness, disability and premature death.***
5. ***Provide accessible, affordable, appropriate health services for all.***

(Premier's Council on Health Strategy)

ACKNOWLEDGEMENTS

The Health Care System Committee members were greatly assisted in their work by the consulting studies which we commissioned. The funding and incentives study was carried out by Stevenson Kellogg Ernst and Whinney and Price Waterhouse produced a report on the future development of community services. These two studies provided the background information necessary to allow the committee to set forth the directions and recommendations contained in this report.

The committee also wishes to thank Dr. Martin Barkin, Deputy Minister of Health, Marilyn Knox, Executive Director of the Premier's Council on Health Strategy, Glen Heagle, Senior Advisor for the Office of Senior Citizens Affairs and Michael McEwen, Area Planning Coordinator for the Ministry of Health for their valuable contributions to the committee.

In addition, the committee owes a great deal of thanks to all the participants who gave so graciously of their time and knowledge at our Expert Panel Conference.

Finally, the committee wishes to acknowledge the efforts of Lorne Zon, who was responsible for managing all facets of the project and for preparing our report.

SPECIAL ACKNOWLEDGEMENT

The Premier's Council on Health Strategy, and the Health Care System Committee in particular, were deeply saddened by the loss of Father Sean O'Sullivan. His contributions were extremely valuable to our work. He will be missed.

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PREFACE

THE PREMIER'S COUNCIL ON HEALTH STRATEGY

In 1987, the Government of Ontario received three major reports on health and health care.

The first report, *Toward a Shared Direction for Health in Ontario,* reviewed the major issues in health care in Ontario, set out a philosophy and designated priority issues to be addressed.

The second, *Health for All Ontario,* presented a series of health goals designed to provide a policy framework for health and to set the stage for developing specific objectives and targets that could guide resource and program planning.

The final report, *Health Promotion Matters in Ontario,* reviewed the state of health promotion in the Province and provided a meaningful pulse on what is important to communities and individuals in establishing health promotion programs. As well, it provided a broader context for approaching health and emphasizing consumer involvement.

These reports have had a major impact on the future of health in Ontario. One of the significant steps taken in response was the establishment of the Premier's Council on Health Strategy.

Our mission

The mission of the Premier's Council on Health Strategy is to provide leadership and guidance to the whole government in achieving the goal of health for every citizen of Ontario.

Our view of health

The Premier's Council has adopted the World Health Organization's definition of health cited at the beginning of this report.

This is a broad concept of health. Health is not only the absence of disease or illness but is also a positive resource that allows people to cope with, adapt to, or influence the pressures of daily living. Health is not only an objective to be sought but an asset to be used to help us achieve our objectives.

What are our beliefs?

We believe that improving the health of all Ontario residents can be achieved by:

- ensuring greater emphasis on promoting and maintaining health;
- providing access to a balanced system of treatment, health promotion and disease prevention;
- creating social and physical environments conducive to health;
- empowering individuals to make informed decisions that affect their health;
- creating strong communities that can mobilize their resources to support health;
- working together to maximize our opportunities to achieve health.

The Council's mandate

The Premier's Council on Health Strategy was established to reflect the high level of political commitment, from government as a whole, to examine policy options for the future direction of health and health care in Ontario. The Council's mandate is to establish priorities and to build consensus for change in partnership with health care providers and community representatives.

In order to fulfill its mandate, the Council will be expected to:

1. select specific goals to achieve the improved health of Ontario's residents and establish specific targets and priorities which can be measured, evaluated and implemented;
2. recommend specific public policy initiatives which are required to improve the health of Ontario's residents and which are beyond the traditional jurisdiction of the formal health care system;
3. identify initiatives to develop public policy which emphasizes health promotion, disease prevention and community alternatives to institutional care;
4. recommend innovative approaches to health care which are sensitive to the diverse needs of the province and which foster personal

responsibility for health, the appropriate use of resources by individuals and health professions, and which enhance linkages between health and related human services; and

5. advise and assist the Ministry of Health in establishing the criteria and priorities to guide the allocation of the Health Innovation Fund and monitor the performance of projects approved for funding.

The membership of the Council

The composition of the Premier's Council reflects the principle that all interested parties must be involved in achieving our mission.

The Council is chaired by the Premier, with the Minister of Health as Vice-Chair. The external advisors bring their expertise to the Council as consumers, business, labour representatives, members of the health professions, district health councils and universities. The Ministers of the Management Board of Cabinet, Community and Social Services, Housing, the Environment, for Senior Citizens' Affairs and for Disabled Persons are active contributors.

The Council's Committees

There are five committees within the Premier's Council, each with the responsibility of carrying out one component of the mandate. A steering committee, chaired by the Minister of Health, coordinates the activities of the committees.

The five committees are:

- Health Goals
- Health Care System
- Healthy Public Policy
- Integration & Coordination
- Health Innovation Fund

INTRODUCTION

The issues confronting the providers and users of health services in Ontario, from governments and health professionals to the general public, are common to all jurisdictions in Canada and to most other developed countries. There are no simple solutions to the problems facing the health care system. This situation is not, however, a rationale for maintaining the status quo. The Health Care System Committee believes that the status quo cannot and should not continue. The pressures on the system, whether they be demographic, technology driven or cost based, demand thoughtful consideration and identification of solutions. A start to the implementation of changes and planning for the longer term future must take place now.

Change is a natural and necessary process in every area of our life, and certainly within governments and businesses. Change can be planned and managed or allowed to take place on a piecemeal and uncoordinated basis. While the former is preferred, the latter, unfortunately, has often been the reality. This report is intended as a step towards the introduction of needed change.

The recommendations in this report represent the culmination of nine months' work by the Health Care System Committee. In undertaking the challenging task of reviewing and recommending health care system alternatives, the committee has been assisted by members of the Premier's Council, experts in the health and social service fields and by independent consulting firms.

A lesson learned early in this process is that there are many things that are right about our existing health care system and the way it functions. In developing a blueprint for the future, therefore, it is essential that the system's strengths be recognized and ways to build upon the solid foundation be found.

The committee is neither so bold nor so naive as to think that we have all the answers. We do feel however, that the recommendations contained in the report provide a starting point for a managed change process. The report does not conclude the committee's work plan. As further strategies and recommendations are developed to address related problem areas, including human resource issues, the committee will bring those to the Council for review.

THE CONTEXT

PREMIER'S COUNCIL ON HEALTH STRATEGY

The mission of the Council is to provide leadership and guidance to the whole government in achieving the goal of health for every citizen in Ontario. The World Health Organization's definition of health, adopted by Council, promotes a very broad concept of health. The health care system, managed by the Ministry of Health, is only one determinant of the health of our citizens.

The Health Care System Committee has undertaken the task of developing recommendations that will allow the health care system to support this broad concept of health. This involves both a reorientation of service and delivery patterns, greater community involvement and enhancing the ability of the government to predict its resource requirements. Regardless of whether the services are directed at health promotion, disease prevention or treatment, improved health should be the goal.

The activities of the Premier's Council and its committees provide the overall context for health within which the Health Care System Committee operates.

PRESSURES FOR CHANGE

Canada currently is second only to the United States in per capita spending on health care. Within Ontario, health care expenditures account for a third of the provincial budget, and health costs have increased 50% in real terms since 1977/8.

The rapidly rising cost of the health system is of even greater concern when demographic trends are considered. Like all industrialized nations, Canada is faced with an aging population that will place increasing demands on the health care system. Canada has the second lowest population age profile of all industrialized nations. Our consulting study estimates that should current trends in health expenditures continue, by the year 2011, taxation levels will increase approximately 2.5 times (i.e. total Ministry of Health cost per taxpayer) if current standards are maintained.

Increased technology may add considerably to this scenario. Technological change in most sectors leads to improved productivity and decreased costs. In health care, although potentially improving health outcomes, the result often has been cost increases. Research and development efforts in the health field have not received the level of financial support common to industry on a worldwide basis. Increasing research and development support is needed and should be directed towards a better balance between methods to improve productivity factors and quality of care.

Even if we as a society are prepared to accept escalation of health care costs, we must ask ourselves: How will increased spending benefit our health and at what cost to our other social, economic and cultural objectives.

However, it is not only fiscal imperatives that have prompted the committee to seek alternatives to improve the health of Ontarians. Numerous studies have shown that different models - such as an enhanced community services sector - can more sensitively and effectively respond to local community needs. The balance and linkages between the institutional and community sectors can and should be improved to ensure the best use of dollars spent. The challenge is to look for ways to meet the often competing objectives within a universal health insurance scheme of equity of access, quality of care and cost control.

PARAMETERS OF THE STUDY

The committee began with several ground rules:

1. The committee accepted as a starting point the directions contained in three reports received by the Ontario government in 1987. *Toward a Shared Direction for Health* (Evans Report), *Health for All Ontario* (Spasoff Report) and *Health Promotion Matters in Ontario* (Podborski Report) are the culmination of a series of studies in Ontario and Canada over the last 15 years. The Evans Report pointed out

that previous studies have laid a well-founded and credible framework for action. The committee has chosen not to continue the debate on directions but to look for ways to turn the framework into action.

2. Economic and demographic pressures necessitate that more effective ways to deliver health care services be found in order to sustain quality and access over the next decade and beyond.
3. The health care system is only one contributor to achieving and maintaining health. However, the resources dedicated to this sector, if they continue to rise at the current rate, may jeopardize the ability of government to support other important health and social objectives.
4. Changes to the health care system should proceed within the overall context of the Council's mission and the activities of the other committees of Council.
5. Our strategies must recognize the political, public and vested interest realities that exist. Plans that cannot be implemented serve no purpose.
6. The committee should not become embroiled in today's problems but look towards the future. The year 2000 has been chosen as the target date for completing the implementation of all the recommendations contained in the report.

PRIORITY ISSUES

Early in its mandate the committee identified three priority issues to be studied:

1. Funding and incentives in the system.
2. The future development of community services.
3. Human resource needs of the system.

The committee decided to focus on the first two issues during the initial phase of its workplan. Human resources would then be looked at with a view to assessing issues arising from phase one.

WHAT WE'VE DONE

Decision to study

In April 1988, the committee developed two requests for proposals for consulting studies. The purpose of the first study was to evaluate the current funding and incentive mechanisms in place and to recommend options for how to introduce new mechanisms to achieve a more effective use of resources. The second study examined options for the future development of a strengthened and enhanced community services sector.

Consultants

Proposals were received from several firms. The committee analyzed the submissions in terms of their proposed methodology, scope, understanding of the issues and composition of the study teams. A short list of firms were interviewed to further probe their approach and assess the group's strengths and weaknesses. Based on the information collected two firms were selected to carry out the studies.

Timeline

Stevenson Kellogg Ernst and Whinney was chosen to undertake the funding and incentives study and Price Waterhouse the community services study. The projects began in August 1988 and final reports were received in March 1989. During the course of the studies the committee met several times with the consultants to review findings and discuss directions.

Expert Panel Conference

In January 1989, an Expert Panel Conference was held to test the preliminary findings of the studies. The conference brought together 43 individuals representing Council's committees, hospitals, physicians, consumers, academia, World Health Organization, Premier's Commission on the Future Health Care of Albertans, social services and the Ontario government. The purpose of the conference was to review the consultant findings, explore new ideas and determine whether consensus existed on the proposed options and strategies.

Premier's Council on Health Strategy

Since the conference the process of refining strategies and recommendations has continued. The Health Care System Committee's findings were reviewed in depth and adopted by the Council. This report puts forth the initial recommendations of the Premier's Council on Health Strategy to the Government of Ontario.

GENERAL OBSERVATIONS

FOUNDATION FOR THE FUTURE

Ontario's health care system is built upon a number of strenghs and resources. Ontario is fortunate to have a dedicated, well trained and highly skilled supply of health providers. Our institutions provide a full range of secondary and tertiary care. Primary care services are offered through a variety of settings. Promotion services are beginning to gain acceptance and recognition as an important partner in achieving improved health. Through our public health system and other mechanisms, prevention and control of communicable diseases continues to show improvement.

VALUES

While the impetus for change is deeply rooted in the financial imperatives facing the system, the strategic plan that the committee is developing must encompass a much broader set of values. The Evans Report, Council's mission statement and our consulting studies all describe sets of values that must be considered. Although the stated values of each differ to some extent, they share in common the need to balance decisions within a competing set of values. In some instances cost-effectiveness may be the prime value but in other cases equity, dignity or quality of life must take precedence.

HEALTH CARE FUNDING

There has been continuing debate on whether the health care system is adequately funded. Canada and Ontario spend more on health care (on a per capita basis) than any other industrialized country with national health insurance. However, we have not necessarily achieved comparatively better health status.

The committee believes that the infusion of more private or public money is not the answer at this time. The resources dedicated to the health care system can be better utilized. Reallocation of resources, as discussed in this report, should allow us to receive greater value in terms of improved health from our tax dollars.

Once the impacts of the changes recommended in the report have been implemented and evaluated, the issues of adequacy and alternative methods of funding will be more apparent. At that time the government should consider necessary changes to both the level and ways in which funds are generated.

STAKEHOLDER TENSIONS

Change is natural and normal. It can also be threatening. However the opportunity exists to reduce the tensions that can develop between those stakeholders such as government, health providers and consumers and amongst sectors of the system. By promoting and providing specific mechanisms for cooperative planning, the change process can offer positive opportunities to address the problems and pressures facing the various stakeholders.

COMMUNITY/INSTITUTIONAL BALANCE

Our health care system is characterized by having one of the highest institutionalization rates in the world. The community health services sector has developed primarily as an outgrowth or safety valve to the institutional sector. In many other jurisdictions, community services have long been viewed as an integral partner in the health care system. In Ontario, a fundamental step in the rationalization and development of community services must be the creation of a clear and accepted vision of what community services should be and the cooperative roles that institutions and community based services can play in the provision of an integrated, continuum of health and health related services.

In our study the committee envisaged community services as programs shaped by and offered to people who live in close proximity. The focus is on keeping people healthy and living independently in their own homes. The emphasis is shifted to the individual and recognizes the consumers' right and responsibility to live independently.

In developing our strategies, the committee was advised by the expert panel not to uncritically accept the premise that community services should be expanded. It was pointed out that such a strategy by itself was not sufficient. To make a difference, it was first necessary to define community services, indicate why they should be an integral part of the system and be more explicit as to where and how allocated funds should be directed. At the same time, it was pointed out that expectations for evaluation of community services should be no different than what we expect from institutions.

FLEXIBILITY

Another major theme to emerge from the deliberations was the need for flexibility in funding. This theme has a number of related components. Current funding mechanisms for most parts of the system are rigid and do not take into account local geographic, demographic and cultural differences. Innovation is stifled by the need to fit into rigidly defined funding criteria. Programs that link or coordinate elements of the system - an explicit objective of government - are often victims of the very problem they are designed to overcome.

INTEGRATION OF FUNDING METHODS

Related to the issue of flexibility is integration of funding methods. Hospital funding and physician payment systems are based on conflicting incentives. Funding for community services - for such programs as home care - are not planned and integrated with the sectors they must serve.

COMMUNITY INPUT

Community input into the planning and design of local health services is very limited. District Health Councils are the major vehicle for achieving this but are limited by mandate and resources. The readiness and ability of communities to take on an active role in determining the range of health services offered in their areas must be recognized and encouraged.

If increasing local participation in the planning and managing of community services is a major objective, then to make the shift possible, the government must be willing to provide the necessary resources and assistance to community organizations.

COMMUNICATIONS AND SUPPORT BUILDING

The inevitability of change must be accepted if the integrity of the system is to be maintained in the next century. Public understanding of the need for and benefits of change is the cornerstone to success for all the issues in this report. The public, government and health professionals must understand the current pressures and the opportunities that exist for improvement. Well informed publics will help provide leadership in identifying and responding to needed changes rather than reacting to pressures as they arise.

At the Expert Panel Conference, the committee was advised to develop a broad range of communication strategies. A significant public education campaign must be mounted to increase general awareness and make possible informed choices about future service options. Campaigns should provide, without resorting to scare tactics, clear and concise information on what the current situation is, why change is required and the variety of choices that exist in how health services can be delivered.

STRATEGIC DIRECTIONS

The consultant studies provided the committee with a thorough review of the issues that need to be addressed. Analysis of these issues allowed the committee to priorize areas for immediate and long term action. Funding and incentives and community services were looked at in terms of vision and direction. Obstacles and opportunities were identified and planning and policy initiatives developed.

In selecting and refining actions for recommendation, the committee has reached consensus on four elements of a strategic plan. A prerequisite to all the elements is the need for a comprehensive public education strategy to educate and inform the public about the issues and choices available.

While the plan indicates immediate action in some areas, it is emphasized that they represent commitments to a long term strategy consistent with the mandate of the Premier's Council on Health Strategy.

STRATEGIC DIRECTIONS; THE ELEMENTS

1. Hospital Funding Systems
2. Physician Payment Methods
3. Community Services Development Opportunities
4. Organization & System Linkages

HOSPITAL FUNDING SYSTEMS

OPERATIONAL FUNDS

Problems in the funding of hospital operations result from a number of interrelated factors. The major funding method for hospitals in Ontario is global budgeting. This arrangement provides hospitals with a fixed budget for all services and an annual adjustment for inflation. Global budgeting as applied today:

- discourages bottom-up responsibility for controlling costs and encourages a growth mentality;
- has failed to address inequities in hospital budgets. Those hospitals that began with a good base budget have prospered while those who didn't can't escape the cycle. The methods used for annual budget adjustments for growth and workload have not proven effective;
- highlights the competing incentives of physician payment and hospital funding systems;
- concentrates on inputs rather than health outcomes. Hospital operations have been judged on their efficiency in managing their expenditures. In future, evaluation should concentrate on what impacts the expenditures are having on improving the health of the communities and populations they serve.

Despite these drawbacks, a global budgeting approach has a number of advantages over other funding methods. Two key advantages are predictability of costs (to government) and (potential) hospital flexibility in expenditure patterns. The committee recommends that a modified system of global funding continue to serve as the core funding method for hospitals. The modified global funding arrangement must be more sensitive to each hospital's particular circumstances. To accomplish this the committee recommends that base budgets for hospitals should be developed using a case mix approach which recognizes the differences in hospital workloads.

The committee also recognized that other opportunities exist to improve equity in hospital budgeting methods. Other mechanisms that should be implemented include:

- targeting of funds
- integration of funding methods
- flexibility

Targeting of funds

If a shift in resources to outpatient and community services is to be realized then specific targets for both should be set. Incentives and disincentives will be required to make the shift a success. Providing additional funds (add-on approach) will not accomplish the objectives. Programs and services which conflict or are neutral to achieving the shift should be discouraged through disincentives.

Incentives can provide strong motivation for change. It is suggested that reallocated or additional hospital funding; such as new program funding or new service opportunities arising from program rationalization, be directed towards those hospitals delivering high quality, cost effective care based on peer group comparisons.

Integration of funding methods

Key to predicting and maintaining budget allocations is the harmonizing of funding and care incentives between physicians and hospital administrators. Mechanisms such as physician involvement in clinical unit budgeting and program funding with predetermined measurable objectives should be explored.

Flexibility

The need for flexibility in funding arises in virtually all parts of the health care system. If we wish to accomplish change we need to allow hospitals the opportunity to experiment and introduce innovative and creative ways to deliver services. Incentives similar to those articulated in the Health Innovation Fund along with greater autonomy to trade-off programs and services within their budgets could be beneficial. Hospitals would then be able to better adjust the range of services they provide in line with community needs.

CAPITAL FUNDS

The committee is concerned that the implementation of the $850 million capital plan for hospitals announced in 1986 could have very negative long term effects on the system.

Original costs for the plan have escalated significantly. Of even greater importance is the fact that capital expenditures represent only a fraction of the ongoing costs to the system. Future budget demands resulting from the introduction of about 4000 new beds may severely limit the ability to shift the community/ institutional balance.

Interjurisdictional comparisons are difficult due to a number of factors. However it has been estimated that Canada already has a ratio of patient days per 1000 that is at least 25% higher than in the United States. A number of accommodation surveys in Ontario estimate that 10% of acute and 25% of chronic care patients are inappropriately placed.

Before proceeding with the original plan, a major review of the present capital plan should be undertaken. The review should look at the full range of alternatives that capital funds could be used for to meet anticipated demand through improved patient placement, community alternatives and redirection of existing inpatient programs to the community.

Provincial priorities must be established for disbursement of these funds. As well, priority should be given to projects that do not increase operating costs, address occupational health and safety concerns or lead to delivery efficiencies that reduce operating costs.

Capital projects for new beds are necessary. The decision whether to proceed with planned expenditures must be based on clearly defined need. In determining this need, it must be shown that other mechanisms such as community based services (which may reduce demand for inpatient services), extended care, duplication or potential rationalization with neighbouring hospitals and health status indicators of the client population have been studied. Where needs for new beds identified in the original plan can be clearly defined, projects should proceed as quickly as possible. In other cases funds should be redirected to those alternatives identified in the review process.

PHYSICIAN PAYMENT METHODS

Physician reimbursement policies obviously have profound implications for overall health care costs.

The dominant source of funding for physicians in Ontario is fee-for-service. Total Ontario Health Insurance payments to physicians and other practitioners quadrupled in a ten year period from $900 million in 1977/8 to $3.6 billion in 1987/8. This growth rate of 15% per year far exceeds the growth rate of the provincial economy. Continuation of this rate of additional resource consumption cannot be sustained. For this and other reasons, the committee has examined options available for physician reimbursement and the impacts of each alternative.

CONSULTANTS FINDINGS

The consultants undertook a review of remuneration systems used in Ontario and in other jurisdictions. The range of payment methods in use can be summarized as follows:

- Fee-for-service
- Modified fee-for-service
  - capped
  - weighted (e.g. geographic)
  - health promotion element (or other priority)
- Capitation
  - individual
  - Health Service Organizations (HSOs)
  - Weighted (e.g. special needs groups)
- Salary
- Mixed reimbursement system

Fee-for-Service

Fee-for-service, in its current form, has been supported by the Ontario Medical Association and many independent physicians. Their position is that it rewards productivity and provides for clinical freedom. On the other side, some physicians are concerned that the rigidity of the fee schedule limits certain important and efficacious procedures, eg. prevention, promotion. As well, some physicians express concern that low Ontario Health Insurance fees force them to practise "turnstile" medicine that compromises the quality of care they would prefer to deliver.

The fee-for-service scheme in place today is open-ended. No limit is placed on the amount of expenditures through Ontario Health Insurance. Since the early 1980s, Ontario Health Insurance payments to physicians have exceeded inflation each year. This has become a major concern.

CAPITATION

Capitation provides payment on the basis of the number of patients to whom care is being provided rather than the number of services provided. Since payments are not linked to services, physicians are free to determine the way in which they practise. Capitation can offer physicians savings through reduced administrative workload. Capitation is more conducive to the multidisciplinary approach used in community health centres (CHC) and health service organizations (HSO).

Criticisms of capitation have been raised regarding the sensitivity of the funding formula to workload differences resulting from the health status of patients and potential incentives to provide less service than may be necessary. Since patients are not locked-in, physicians may lose capitation payments for patients who, for reasons beyond the physician's control, decide to seek care elsewhere.

SALARIED PAYMENT

Salary reimbursement shares many of the same advantages and disadvantages as capitation. Under a salaried scheme, physicians income or practice style is not influenced by the number of services provided. Salaried payment and capitation vary with respect to the impacts of the employing organization's policies for how employees should conduct their practices.

The potential loss of independence to a "civil-service" type system is a major concern of many physicians. Another key factor which concerns physicians is that a salary situation prevents individuals from directly determining their income levels.

Salaried positions can bring with them certain advantages such as paid overhead, recognition of experience and excellence and fringe benefits such as maternity leave and pensions.

Two key advantages of a salary system are the ability of government to more accurately predict its resource requirements and the administrative ease for both the government and doctors.

EXPERT PANEL DISCUSSION

Much of the debate over the various methods of remuneration is steeped in history and cloaked in rhetoric. At the conference it was generally believed that this rhetorical posturing only serves to cloud the debate and distract from the benefits of a mixed approach. The panel pointed out that alternate payment methods offer many advantages for community based practices such as CHCs and HSOs. Fee-for-service does not encourage the use of paramedical supports. As well, fee-for-service does not normally provide for community input into the range and type of services they wished to have delivered.

At the Expert Panel Conference, there was general consensus on four fundamental principles for physician payments:

1. Any payment scheme should provide incentives which serve the objectives of:
   - meeting provincial health goals,;
   - permitting fair and adequate remuneration;
   - protecting the right of physicians to act as their patients' advocate; and
   - recognizing the government's need to predict costs. Any open-ended system must be modified to allow for reimbursement within established limits.
2. Fee-for-service, capitation and salary are all legitimate forms of reimbursement and should be so recognized by both government and physicians.
3. A more mixed system of remuneration methods which benefits from the strengths of each payment method is a desirable objective.
4. Physician choice in selecting a remuneration method is desirable.

The committee recognizes that different remuneration methods achieve different objectives. Each of the remuneration methods have distinct advantages and disadvantages. All of the methods can be improved to better meet the needs of consumers, providers and governments.

It falls to the government to look at ways to encourage a more mixed reimbursement system. If certain types of practice settings are better served by a particular payment method, then incentives to encourage its use should be designed. As well, research into the impacts of each payment method must be undertaken so that longstanding differences of opinion can be properly evaluated.

DISPUTE RESOLUTION

The conciliation/mediation techniques for negotiating physician compensation have been unsuccessful. As we move towards a more mixed reimbursement system, the need to determine more effective negotiation techniques will become more critical. As an interim step, binding arbitration should be considered as a method for dispute resolution.

EXPENDITURE PLANNING

The committee recognizes the need for the government to be able to predict costs regardless of the type of remuneration method in place. Being able to do so will require a better understanding of certain contributors, for example utilization of physician services and the impacts of practitioner supply will be necessary. Mechanisms to modify the effects of these factors can be addressed by a number of means such as a more balanced mix of payment methods, sharing of unexplained growth in the number of physician services being provided or funding envelopes. An acceptable compromise should be negotiated.

PHYSICIAN SUPPLY

The committee makes one final observation. Success in meeting the dual objectives of health goals and fairness of income cannot be maintained in the long run without the implementation of human resource plans.

A major contributor to rising Ontario Health Insurance expenditures has been the increase in physician supply. Even with the current supply of physicians, many northern and rural areas remain underserviced. As well, even with the increased supply, there is a continuing increase in the number of services provided per physician. It must be recognized that normal market forces don't apply to health care services and that other strategies to predict and control costs must be developed.

FUNDING AND INCENTIVE ISSUES REQUIRING FURTHER REVIEW

Defining benefits

The committee believes that in the longer term all provinces may need to undertake a fundamental look at what is and should be covered under health insurance. The original intent of health insurance was to ensure that a person receives necessary medical care regardless of financial status. Most provinces, including Ontario, have gone far beyond this in terms of programs and services offered. The committee is not suggesting a return to first principles; rather that if economic considerations require changes or trade-offs, the basic purpose of health insurance should not be forgotten.

COMMUNITY SERVICES DEVELOPMENT OPPORTUNITIES

RATIONALE FOR COMMUNITY SERVICES DEVELOPMENT

Much attention has been given to the importance of strengthening community services in the Ontario health care system. A succession of reports over the last few decades have put forward the rationale for enhancing the role of services provided in the community. However, many of their recommendations have not yet been translated into action.

There are common threads that run through the rationale offered by these reports:

- concerns about costs of care and the future cost impacts of projected demographic change and changing patterns of illness;
- concerns about an over emphasis on treatment rather than illness prevention, health promotion and maintenance;
- concerns about fragmentation and lack of co-ordination;
- belief that community services are more responsive to individual and community needs and to the needs of "special" and disadvantaged groups; and the
- desirability of non-institutional care compared to institutional care.

Virtually all these reports see community services as intrinsically more responsive and which, by the very nature of their setting, contribute to quality of life.

It is the view of the committee that the principal challenge is not so much to develop new proposals for delivering community services but to understand why past recommendations have not been implemented and to identify strategies to overcome implementation barriers.

DEFINITION OF COMMUNITY SERVICES

The committee has defined the major attributes of community services as follows:

focus
- on the individual's independence
- address local needs
- have a direct impact on health

locale
- home-based or in the community

accountability
- decision-making is made by those in the community and those providing the service

providers
- partnership of professionals, non-professionals and volunteers.

The key is to define the primary characteristics of community services. The actual providers and arrangements must vary to accommodate local circumstances.

COMMUNITY SERVICES AS A COST-EFFECTIVENESS STRATEGY

In many debates regarding community services, cost-effectiveness (particularly as a substitute for institutional services) is used as the major premise both for and against expansion. The committee requested that the consultants review the literature on this issue.

The review shows the following:

- it is too simplistic to think of community services primarily as a cost-effective alternative to institutional services. In some cases they are, in some cases they may be, and in others they are not comparable;
- there is only partial congruence between community service populations and institutional service populations. Many types of community services do not serve groups who would otherwise be in institutions;
- where there is some overlap between community and institutional services (such as in long term care), a narrow approach that focuses exclusively on the role of community services as a cost-effective alternative may ignore other important considerations, including quality of life, flexibility, client independence, family burden and fundamental preference.

MAJOR DIRECTIONS

Three major directions are proposed for implementation:

1. To enhance the responsiveness, accountability and effectiveness of community services by:
   - expanding the scope of community services with greater emphasis on prevention, promotion and health maintenance;
   - achieving more flexible program funding and delivery methods;
   - vesting greater power and responsibility in the community sector; and
   - achieving a broader use and participation in community services.
2. To achieve recognition that the community services sector can make a contribution to health that is as least as significant as that of the institutional sector.
3. To make the institutional sector more responsive to the community sector and to community needs.

The committee supports the development of a community services sector incorporating health, social service and other health related programs. In order to begin the process, the committee found it necessary to limit its discussions primarily to community *health* services. It is felt that the directions and process recommended in the report can be expanded over time to incorporate a much broader range of services.

EXPERT PANEL CONFERENCE

The Expert Panel Conference strongly supported a deliberate shift in emphasis and related resources to the development of community services. In doing so, several cautions were raised:

1. It is not sufficient to commit additional resources. A clear vision of what community services are and should be is required.
2. The vision should define why the shift is beneficial, where funds will be directed and how this will be achieved.
3. The objective should not be limited to cost-effectiveness. Equity, quality and access are important and may introduce competing values for priority in resource allocation.
4. Community services must be accepted as an equal partner with institutional care in the provision of health services.
5. Public awareness is key to achieving success. We cannot expect the public to accept the shift without understanding why it is beneficial.

The committee accepted these cautions and feels that these issues have been addressed in the community services study.

At the conference, discussion regarding implementation of a shift to community based services centred on funding strategies, professional education and communications and support building.

COMMUNITY SERVICES FUNDING STRATEGIES

Funding strategies must be based on a planned and purposeful targeting of funds. Resource allocation is the main lever available to ensure change strategies are implemented. This strategy, in effect, is an investment in meeting the objectives being set for the future design of the system.

The committee believes that undertaking more studies is not the answer. Instead it is recommended that funding for community services be doubled within a defined time period and that a specified percentage of provincial funds be earmarked for promotion and prevention activities.

Implementing these targets does not require an infusion of large amounts of additional funds. The shift in resources should come primarily from a redirection of existing resources and specific allocations of annual increases (eg. percentage of health budget or percentage of growth in GPP).

A major theme in discussions around funding for community services was flexibility. Currently funding criteria for community services are rigid. Many innovative proposals or potential demonstration projects can't get tested because of the rigidity.

The division of program funding into compartments is simpler from an administrative perspective, but this approach does not recognize the realities of many health problems. A program model rather than a service funding model provides flexibility in meeting individual's health needs. Legislative and policy reforms will be necessary. As well, new forms of organization and management must be developed and tested. Enhancing local planning and accountability and funding envelopes have been suggested by both consultants studies and supported in principle at the Expert Panel Conference.

The development of community services must be evolutionary not revolutionary. Public and professional attitudes can be changed through information and demonstration. Pilot projects that allow for community input and choice should be encouraged.

IMPLEMENTATION MECHANISM

The implementation of a community-based system as outlined above can not be easily facilitated by the ministries' organizations as they currently exist. The committee recommends that a special task force or unit be established to oversee the implementation. It will be necessary for a lead Deputy Minister to be designated to coordinate and negotiate interministerial boundaries and resolve problems that may arise.

The unit should lie outside the participating ministries and have a reporting relationship to either Cabinet Office or the Premier's Office.

PROFESSIONAL EDUCATION

A shift in attitudes and enhanced interest in a community services career will require a fundamental change in the curricula of the traditional professions.

The system should drive training - not the reverse.

The process should begin by defining what we are training for and why. Consumer input in defining needs is vital. This would lead to an assessment of what is right about how we train and what is lacking. The assessment may show the need for new types of health workers or professions. If lower costs are an objective, then it is questionable whether this can be achieved by simply moving the current range and mix of health professionals from institutions to the community.

In the training process, a broad approach to health and its many determinants should be fostered. Given the rapidity with which current knowledge becomes obsolete, it will also be necessary to refocus the educational approach to a learn to learn model. Health policy, promotion and prevention, limits of treatment and organizational impacts should all be included in core curricula of providers as well as health planners and administrators. Changing the way we prepare and train our human resources will have a significant impact but must be reinforced through new methods of continuing education.

The breaking down of traditional roles and practice patterns will also be necessary if a community services system is to work. One of the major problems that exists today is a lack of awareness of community alternatives available to providers. Physician referral patterns do not encourage movement between institutions and the community or between physicians and non-medical services. Joint training of various care providers should be encouraged and ongoing methods of keeping practitioners aware of community alternatives developed.

A mechanism needs to be put in place to initiate these changes. One method is to establish a joint committee of representatives from the Ministries of Health, Colleges and Universities, professional colleges, consumers, providers and the teaching institutions.

Through this mechanism each Health Science Centre would be required to establish linkages with community services, implement mandatory core curricula and practicums in community services, etc. Additional funding that becomes available would be linked to meeting these objectives.

COMMUNICATIONS AND SUPPORT BUILDING

There are a variety of messages and groups that need to be targeted. At present there is a perception problem and lack of public information. In addressing the need for community services, information about costs, fairness in access, quality of life, technological choices and individual responsibility must be made readily available. Information must be tailored to specific audiences including the public at large, providers and consumers.

At the Expert Panel Conference it was suggested that pilot projects which offer communities choice in the way services may be delivered are more effective than providing information alone.

ORGANIZATION AND LINKAGES

The range of health services is broad and complex. Integration and coordination of the spectrum is the responsibility of the provincial government and particularly the Ministry of Health. This structure leaves decisions far removed from the point where service is delivered.

Problems inherent in this method became obvious when it was pointed out that there are over 3,500 community agencies in Toronto with no local presence to coordinate or rationalize services being offered. District Health Councils are charged with planning and advising the Ministry with respect to service delivery but the complexity of the system and the resources and mandate of DHCs make such a task extremely difficult.

A centralized administration can at best provide strategic planning direction to local services. However, even this is complicated since the range of services involved crosses ministries. Enhancement of community services, sensitive to local needs and choice, cannot be accomplished under the present system. Rationalization and integration objectives will also suffer.

In countries that have adopted a decentralized approach to management several distinct advantages have resulted:

1. Service delivery has been depoliticized. Politicization of health care results in resource decisions that are not always in the best interest of achieving health.
2. Related to this is the fact that under a decentralized system direct lobbying of government by individual agencies or associations is diminished. The relative power of vested interests is then more even.
3. Resource decisions made at the local level are better adapted to community needs and desires.
4. Community and individual responsibility for health and more effective use of resources are achieved.
5. Integration and coordination and thus access to services is enhanced.

As with many of the proposals in this report, movement towards a decentralized system should be gradual. Local authorities bring with them many potential pitfalls that could far outweigh the advantages. The shift must be well thought out to avoid these problems.

Many models exist for local authorities. It is first necessary to determine which key services, providers and institutions should be included. The powers the authorities will have and how they will receive and account for funds will also affect the directions taken. Several characteristics of a devolving system have been identified. These include:

- balance of interests
- broadening of services/providers over time
- developing an equitable funding formula e.g. capitation
- determining catchment size and working towards common service delivery boundaries
- defining local vs. regional vs provincial resources.

The committee recommends that a variety of local authority models be tested and that funding envelopes should be used in some of the pilots. Evaluation of the models in terms of meeting set objectives related to cost, quality of care, coordination and integration, improved health outcomes and consumer satisfaction must be undertaken.

In order to accomplish this a variety of scenarios need to be developed with concomitant consequences thought through. No existing models can be easily transferred and superimposed upon the Ontario system.

A key is involving residents from the local test areas early in the planning stages.

RECOMMENDATIONS

The Premier's Council has endorsed the committee's belief that the strategic directions put forward in this report provides an essential framework for overcoming past difficulties in moving from study to implementation.

To assist in achieving action, a series of recommendations in each of the four major areas, as well as several recommendations which serve to complement and enhance these directions, have been developed. Together, the four strategic directions and the specific actions recommended, provide a blueprint for Ontario's health care system in the 21st century.

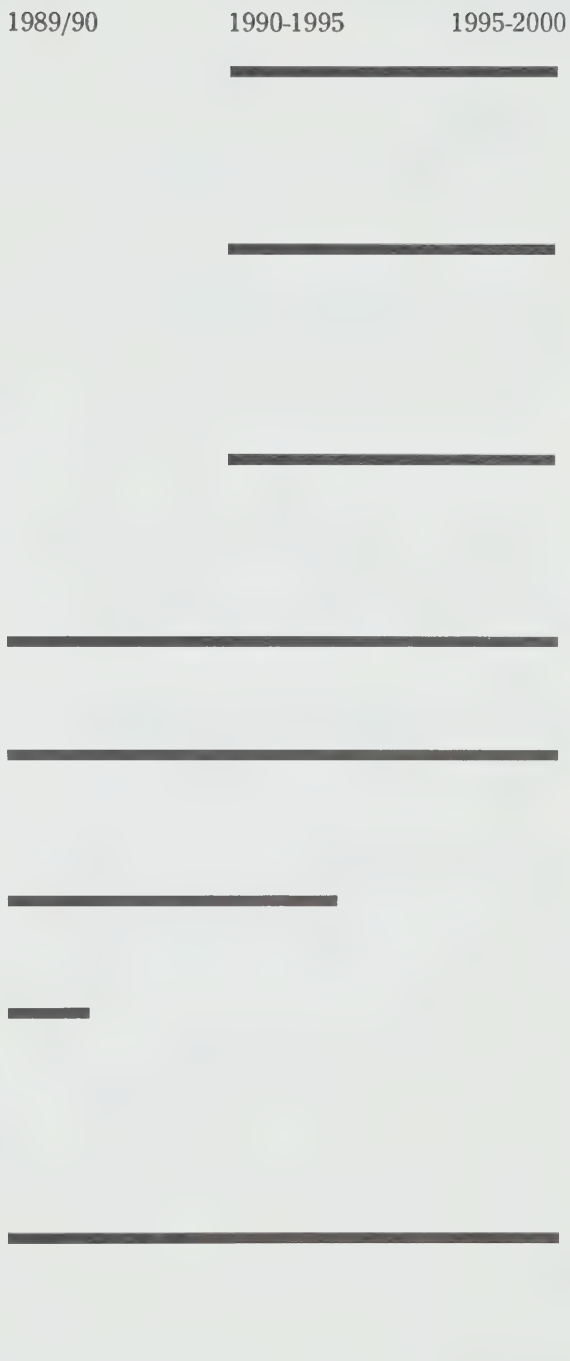
The recommendations begin with two fundamental principles from which the specific recommendations flow.

STRATEGIC STARTING POINT

1. The government should undertake a fundamental shift in emphasis towards:
   - the rationalization and future development of community-based services;
   - the preparation of a provincial strategic plan and standards as a prerequisite to implementing decentralized planning and priority setting in the allocation of health resources.
2. This shift in emphasis should be implemented in a manner consistent with provincial health goals.

HOSPITAL FUNDING SYSTEM

It is recommended that:



1. A modified system of global funding continue to serve as the core basis for hospitals and that base budgets be developed using a case mix approach which recognizes differences in hospital workloads.
2. Other opportunities to improve equity in hospital budgets be explored such as targeting of funds, increased spending flexibility and program funds with predetermined measurable objectives related to provincial health goals.
3. Better incentives be developed that target re-allocated or additional hospital funds to those hospitals delivering high quality, cost-effective care based on peer group comparisons.
4. Budgetary and utilization targets be implemented for hospitals to develop both ambulatory and community-based programs.
5. An immediate review of the $850 million capital plan be undertaken. The review should look at the full range of alternatives to inpatient institutional services.
6. Capital projects that as a result of the review are deemed necessary and reasonable should proceed as quickly as possible.
7. Provincial priorities for capital funds be established which takes into account such factors as:
   - occupational health and safety
   - reduced operating costs
   - no operating cost implications.
8. Cost-effectiveness of new technologies should be thoroughly evaluated in relation to health outcomes, quality of care and provincial health goals.

PHYSICIAN PAYMENT METHODS

It is recommended that:

1989/90 1990-1995 1995-2000

9. The following basic principles be applied in developing and negotiating physician reimbursement:

   a. Any payment scheme should provide incentives which serve the objectives of meeting provincial health goals, permitting fair and adequate remuneration and protecting the right of the physicians to act as their patients' advocate.

   b. Recognize the government's need to predict costs. Any open-ended system must be modified to allow for reimbursement within established limits.

10. A review of remuneration systems should be conducted jointly by the government and physicians to develop options and incentives to support the province's health goals.

11. Pending the development of a negotiated dispute resolution mechanism, binding arbitration should be considered.

12. A spending envelope for physician payments from Ontario Health Insurance should be developed taking into account appropriate factors, such as population growth, age mix, utilization, complexity, experience and physician supply.

Human Resource Plan for Health Services

13. A strategy for addressing the development of a human resource plan should be established.

    (This will be addressed in Phase 2 of the committee's workplan.)

COMMUNITY SERVICES DEVELOPMENT

It is recommended that:

Role and purpose

14. The government should implement a comprehensive strategy for community-based services which addresses:

    - definition of role and purpose
    - funding strategies
    - community input in determining local priorities

- relationship and linkages to institutional services
- human resource training
- information, research and evaluation.

15. The government assign senior level responsibility to oversee the implementation of the community services development strategy (eg. special task force or unit).

16. The scope of the community services network should include all health and social services.

Funding

17. Specific targets for reallocation of existing and growth funding to community services be established.

18. Funding impediments to service collaboration and partnership be eliminated through greater flexibility in the use of program funding streams.

19. Inequities in professional remuneration in community services vis a vis institutions be eliminated.

Community input

20. Measures to achieve a broader participation and responsibility for health and health care be implemented by actively seeking the involvement of broad community representation by individuals, consumers and providers in the planning and sponsorship of new community services.

Human resource training

21. A committee representing the Ministries of Health and Colleges and Universities, professional colleges, consumers, providers and teaching institutions be set up to plan, recommend and monitor necessary changes in the training of professionals to better prepare them to work in community settings.

22. New funding to teaching institutions should be targeted as incentives to those health faculties that have implemented appropriate changes.

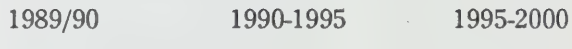
23. Measures be taken to make career opportunities in the community services more attractive.

Information research and evaluation

24. A strategy be implemented to market community services to the public and health professionals through media and professional associations with the aim of improving the image and awareness of community services.
25. Mechanisms be established to ensure organized representation of community services in public policy discussion at provincial and local levels (i.e. local variation of Council at pilot project sites).
26. A community services research strategy be implemented. The Health Innovation Fund be considered as a source of funding.
27. Pilot projects testing new and innovative ways of delivering community sevices be funded and evaluated.

ORGANIZATION AND SYSTEM LINKAGES

It is recommended that:



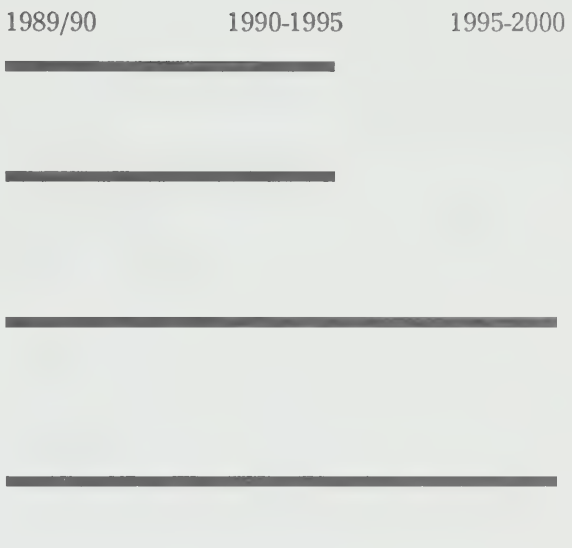
Decentralization

28. A thorough review of the options available for establishing local authorities in Ontario be undertaken jointly by the Integration and Coordination Committee of Council and relevant ministries. A dedicated planning team be designated to oversee the implementation.
29. The government determine an equitable funding formula for local authorities based on key services to be included, linkages to regional and provincial resources, demographic, geographic and other relevant factors.
30. The government implement a number of pilot projects concurrently to test the most viable local structures (with and without funding envelopes) and carefully evaluate the success of each model in meeting

established objectives. Appropriate exit policies be developed should the pilots prove unsuccessful.

PUBLIC AWARENESS AND INFORMATION STRATEGIES

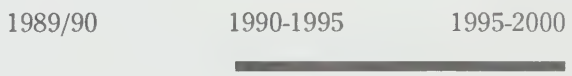
It is recommended that



31. Specific public education strategies aimed at increasing awareness and understanding of community services be implemented.
32. Mechanisms for encouraging and supporting community input into the planning and design of local health services be strengthened.
33. Mechanisms for cooperative planning to reduce stakeholder tensions be pursued.
34. A public education/information program be developed to:
    - clearly outline the current health resources, how they are being used and the implications of existing pressures on future resources;
    - indicate options available for re-orienting our current system;
    - solicit public reaction as to how to implement a managed change process.

RESEARCH

It is recommended that:



35. A doubling of provincial funding for peer review research be made available to support:
    - basic research
    - clinical research (including health outcomes)
    - health system delivery research (including cost-effectiveness)
    - community health research
    - educational research, and
    - technology assessment.

APPENDIX 1: COMMITTEE MANDATE

COMMITTEE MANDATE

HEALTH CARE SYSTEM COMMITTEE

In 1987, the Government of Ontario received three significant reports related to health and health care in the province. *Health for All Ontario* (Spasoff Panel) developed a series of health goals designed to provide a policy framework for health and to set the stage for the development of specific objectives and targets that could guide resource and program planning. *Health Promotion Matters in Ontario* (Podborski Committee) reviewed the state of health promotion in the province and provided a meaningful pulse on what is important to communities and individuals in establishing health promotion services. *Toward a Shared Direction for Health in Ontario* (Evans Panel) reviewed the major issues in health care in Ontario and set out a philosophy, value set and priority issues to be addressed.

The reports go on to identify a number of issues and concerns that must be addressed if the system is to develop in concert with emerging trends and paradigm shifts. As well, new directions for improving the capacity of the system to meet changing needs and demands have also been identified. The need for the Ministry of Health and other ministries to actively plan and provide leadership is evident in all the reports.

Some of the major issues shared by the reports are:

- the health care system is only one element in achieving health (i.e. as defined by WHO);
- there is a need to re-orient the system from its predominance on treatment of illness and achieve a more balanced set of programs incorporating disease prevention and health promotion;
- there is a need to enhance the community-based care network;
- the linkages between institutional and community care services must be improved;
- greater emphasis needs to be placed on intersectoral planning and delivery of service initiatives (health/social service/occupational health/environment) if equity in achieving health is to be realized;
- the health care system must be responsive to local needs through increased opportunity for local planning and decision-making;
- the system requires manpower and financial strategies and incentives designed to support implementation of desired future directions.

Council supports the need to plan a more integrated health care system to achieve a balance between health promotion, disease prevention and treatment services. As well, Council advocates the need to achieve a balance between institutional and community-based services.

TERMS OF REFERENCE

To address the future requirements of the health care system in Ontario, the Council established a subcommittee to provide Council with specific strategies for action. The terms of reference of the Health Care System Committee are as follows:

1. To recommend the key issues that Council will address for the future development of Ontario's health care system based on a review of the major directions outlined in the Evans, Spasoff and Podborski reports and on other factors identified by the committee including those listed above.
2. To develop these issues into a plan for how the health care system ought to be developing, in keeping with the mission and priorities of the Premier's Council on Health Strategy and the three reports received by the government.
3. To recommend both immediate and longer term initiatives that Council should undertake to achieve visible and tangible results.

4. To recommend to Council options for:
   a. funding and incentives that will assist in implementaton of the plan;
   b. manpower strategies for training and regulating current and future health practitioners as it relates to the plan;
   c. pilot projects for funding under the Health Innovation Fund to test and evaluate new delivery methods in support of the plan;
   d. improving local planning and participation in the implementation of new programs and services.
5. To evaluate the pilot projects and develop specific means for an orderly introduction into the health care system.

APPENDIX 2: FUNDING AND INCENTIVES STUDY:

HIGHLIGHTS

Prepared for the Premier's Council on Health Strategy
By Stevenson Kellogg Ernst & Whinney

FUNDING AND INCENTIVES STUDY

INTRODUCTION

The Premier's Council on Health Strategy was established in late 1987 to advise the Premier and government on future directions for health and health care in Ontario. The policy recommendations of this committee are designed to take the health care system in Ontario well into the 21st century. In pursuing its mandate, the Council established five committees.

One of these committees, the Health Care System Committee, identified the need to consider the introduction of alternative methods of funding and the use of incentives to foster new approaches to health care delivery.

To assist the committee in its work, Stevenson Kellogg Ernst & Whinney was engaged to:

- identify current funding and incentive mechanisms used for funding health care services and providers in Ontario;
- assess the pros and cons of each mechanism from the perspective of providers, consumers, and funders;
- determine the impact of current funding methods on the health care system;
- identify funding and incentive options for the Premier's Council to consider, to influence Ontario's future health and health care system.

This study was prompted by an increasing concern within Ontario over the cost and direction of the health system. Discounted for size, Canada currently is second only to the United States in terms of money spent on health care. Within Ontario, health care expenditures account for a third of the provincial budget, and health care costs have increased 50% in real terms since 1977/8.

The rapidly rising cost of the health system is of even greater concern when demographic trends are considered. In common with all industrialized nations, Canada is faced with an aging population that will place increasing demands on the health care system. Canada has the second lowest population age profile of all industrialized nations. Should current trends in health expenditure continue, by the year 2011, personal taxation levels will increase approximately 2.5 times if current standards are maintained.

Another concern about the Canadian situation is our high proportion of health care delivered through hospitals of various kinds. Our country has one of the highest rates of institutionalization in the world. Community support programs, while increasing, still lag behind many jurisdictions. Expenditure on health prevention and research is low in the overall context of the health budget. Additionally, inequitable funding of providers exists.

Within context of cost control and influencing future health delivery systems, we have identified options for the Premier's Council to consider on funding and incentives. We have reviewed the experience of other jurisdictions and surveyed initiatives undertaken in other provinces across Canada. To assist us in our work, we have collaborated with leading academics and drawn upon the experience of our health care consultants in the U.S.A., Europe and Australia.

Professor A.J. (Tony) Culyer, Professor of Economics at the University of York, England, assisted us in reviewing initiatives in other jurisdictions. Professor Culyer is uniquely positioned to assess the relevance of these initiatives to the Ontario situation. He recently published a book for the Canadian Tax Foundation — *Health Care Expenditures in Canada*. We were also assisted in our work by Dr. Jeff Anderson, a member of the academic staff of the University of British Columbia. Dr. Anderson is both a physician and a policy analyst.

During the preparation of this report, we received valuable guidance and insights from the Health Care System Committee and the Council's secretariat. We would like to thank everyone who has contributed to our work.

HIGHLIGHTS

A. INTRODUCTION

The methods for funding the health system in Ontario are extremely complex, as are the issues facing policy makers. An analysis of the health system must examine issues that impact on consumers, physicians and service providers, such as hospitals, nursing homes and community-based programs. These issues also cross ministerial boundaries. While the Ministry of Health and the Ministry of Community and Social Services are the principal funders of health care programs, the Ministries of Housing, Education and Senior Citizens Affairs also have their part to play in the overall health system for the people of Ontario. The roles and responsibilities of each ministry and service provider need to be coordinated in a comprehensive network.

Many complex issues have to be addressed in health funding. Our report therefore is both detailed and comprehensive. To assist the reader, we have prepared a synopsis of the report in this "highlights" chapter. We have also cross-referenced our highlights section to the main body of our report, so that readers will be able to use the document as a reference source to gain more information on issues with which they are unfamiliar.

The report develops through five key chapters that describe our research:

- Chapter III provides an overview of funding mechanisms and sets out how funds are currently allocated to health care providers. It also projects the cost of the current health care system based on varying assumptions.
- Chapter IV sets out an analysis of the ways in which health care providers are paid, including hospitals and physicians.
- Chapter V contains an analysis of a number of issues and problems either currently facing the health care system or problems likely to occur unless changes are made to the system.
- Chapter VI reviews funding and incentive issues and initiatives in the UK, Sweden, West Germany, New Zealand and the U.S.
- Chapter VII sets out a detailed analysis of funding and incentive mechanisms for hospitals and physicians together with a number of other areas that should be reassessed in terms of funding arrangements. The chapter also discusses alternative organizational arrangements.

B. WHAT ARE SOME OF THE KEY ISSUES AND PROBLEMS EXPERIENCED BY THE SYSTEM?

By most measures the province of Ontario has an excellent health care system. Generally, people receive the treatment they require in a timely and caring manner. However there are some problems on the horizon that must be addressed.

Problem area: increasing costs

A major problem within the health care system is that the rate of increase of the health care costs has exceeded the growth rate of the Ontario economy. If this continues, future health care will consume a larger and larger portion of resources in the provincial budget. This will be at the expense of other government programs.

Problem area: discordant funding systems

There is a lack of harmony within the system between the methods of payment for hospitals and that of physicians. Generally, hospitals are paid a fixed global amount whereas physicians are paid on an open-ended fee for service basis. This generates conflict both at the macro and micro levels. Doctors are rewarded for being productive whereas hospitals have to live within fixed budgets that generally do not respond to significant increases in workload.

Problem area: few incentives

The funding system provides few incentives to either providers or consumers to pursue the most cost effective method of treatment: for example, community-based programs as opposed to expensive institutionalized care. We have not developed effective measures of outputs of the system. Hence the majority of our measures and controls relate to inputs such as the staffing levels of hospitals, drugs and equipment.

Problem area: lack of integration
The system is characterized by duplication and lack of coordination. A multiplicity of agencies, supported by government bodies, provide health and related services. The planning and delivery of these services is not always coordinated and integrated. The result is duplication of services and unrealized benefits of rationalization. Also, in some areas, there are barriers to consumer access to the service because of lack of coordination between the various providers. The planning process tends to be directed towards expansion, without consideration of replacement or substitution for existing programs.

Problem area: institutional focus
Our system has a strong traditional focus towards institutional delivery of programs. In terms of institutionalized patients, our system ranks among the highest in the world. At the same time we have almost the youngest population profile among industrialized nations. The majority of our health care dollars are directed towards health care treatment with little directed towards prevention and promotion.

Problem area: high tech health care is expensive
The health care industry has seen rapid advances in the development of high technology and capital intensive equipment. Much of this technology increases the overall cost of the system, albeit in many cases, providing better diagnosis or treatment. The effectiveness of many technological advances has not been subject to rigorous economic anaylsis.

Problem area: high labour costs
A further factor impacting on health care costs is the increase in real terms, of salaries and wages paid to health care workers. Canadian employees are placed much higher in the pay league than some of their European counterparts, particulary support staff.

Problem area: looking after the old and the poor
Our society is becoming increasingly characterized by a breakdown of the nuclear family. This implies that the health care system must be developed to support this aging population, providing care that will not be available through the family. Additionally, health delivery systems will have to respond to the particular needs of the low income families, many of whom have single parents.

The above "problem areas" are where our present health system is experiencing problems or will face problems in the future. The funding systems and options discussed in this report provide an opportunity to resolve some of these issues. But funding and incentives will not by themselves solve all our problems. Organizational and system changes will also be necessary. It is the mandate of the Premier's Council to reflect upon existing funding and incentive mechanisms and adopt approaches that it feels would move the health care system closer to its desired goals. (Chapter V of our report expands upon the issues on problems of the current health care system.)

C. HOW DOES OUR SYSTEM WORK NOW?

A $13 billion a year operation
The Ontario health care system is a multi-billion dollar industry. Within the Ministry of Health alone, more that $13 billion is spent each year on the health of our citizens. The Ministry of Community and Social Services also provides direct and indirect support to health care. Directly, it provides such programs as community support services, the Homes for the Aged, Extended Care Program, etc. In addition, the Ministry of Housing supplies support for housing to citizens who are in need. The Ministry of Education indirectly supports the health care sector as does the Ministry of Senior Citizens Affairs through its Access Fund.

A complex system

The inter-relationship of programs and Ministries results in a complicated health system. This report does not examine the funding and incentive mechanisms for every program provided by these ministries. Rather we have focused on those areas that absorb most of the money. We are also reluctant to duplicate work that is underway in other areas. For example, the Lowy Commission is presently reviewing the Ontario Drug Benefit Program. Simultaneously with our study, community-based programs are also being examined. We have, therefore, concentrated our analysis on programs that represent about $10 billion of expenditures by the Ministries of Health and Community and Social Services. Throughout the report we discuss the implications in other areas. Clearly the adjustment of funding in the institutional areas should provide for additional thrusts in the community.

We use six different formulas for paying service providers

We explain, in Chapter IV, how Ontario has developed over the years a variety of funding approaches for its health and related social services. In general terms, the various funding approaches can be described as follows:

- *Global funding* - generally applied to public hospitals, with a global envelope of funds, adjusted each year for inflation, new programs and growth, with no automatic settlement made at year end.
- *Modified global funding* - generally applied to private hospitals and children's treatment centres in which there is a year-end settlement back to the total global amount.
- *Cost reimbursement* - a less-used form of funding wherein the province reimburses actual costs incurred, notably applied to Ontario's 10 psychiatric hospitals.
- *Fee-for-service* - a payment system based on a rate or fee per unit of service provided, notably applied to physicians and to nursing homes (Extended Health Care Plan).
- *Ex-global formula funding for specific cost items* - most notably applied to public hospitals for increased patient activity, life support programs, growth and some specific high-cost diagnostic equipment.
- *Ex-global actual cost reimbursement* - to public hospitals for approved new and expanded programs.

Our systems for funding have two major objectives: first, to optimize consumer satisfaction and provider ability to maintain service quality; second, to keep health expenditures at a reasonable proportion of the provincial budget.

This balance has been very difficult to achieve. Over the past 30 years, a number of significant alterations have been made to reimbursement systems. Indeed, some form of "exception to the rule" funding adjustments have had to be made in every fiscal year. Clearly, significant amendments are again needed to Ontario's health and social funding systems to assure the ongoing provision of services at desired levels, of both quantity and quality.

D. WHAT CAN WE LEARN FROM OTHER COUNTRIES?

To see if we could learn something useful from other people's experience, we reviewed health-care financing in other countries. Our findings are detailed in Chapter VI. Key points we have identified:

- In Canada, some provincial governments presently put limits on total payments to the province's physicians. The fee-for-service (FFS) system is maintained but the overall billings to the system are capped at a certain level. The FFS mechanism is used to influence the geographic distribution of physicians. For example, doctors in Quebec are paid above scale for practising in under-doctored rural areas, whereas physicians in over-doctored urban settings are paid below scale.
- The United Kingdom and Sweden have established regionalized health agencies. This facilitates the coordination of health development in the broader sense, and brings resource allocation decisions closer to the consumer — and to local needs and priorities.

- The UK has a parallel private hospital sector. Approximately 10% of the population is covered by private health insurance. This has introduced a two-level health care system in terms of access to the system for elective procedures and comfort surroundings.
- Sweden has developed a salary system for its physicians. This provides a control over total payments to physicians. However, the productivity of physicians in Sweden is extremely low by international standards.
- Case-mix-funding systems in the United States have tended to reduce the length of inpatient stay. The number of acute patient days per thousand of population in the United States is approximately 900 compared with more that 1,200 in Ontario. Inpatient costs, controlled by case-mix-funding mechanisms, have fallen. In contrast however, the cost of ambulatory care (not regulated by case-mix-funding) has increased.
- West Germany allows its citizens to choose their own health care insurance coverage once they have reached a minimum salary level. All other insurance is paid by employers. This covers 100% of the costs of required health care.
- The United States lacks universal health care coverage. Approximately 37 million Americans have no health insurance.
- In the UK a regionalized system of resource allocation, based on age, morbidity, and population (the RAWP formula,) is helping to achieve more funding equity.

In its selection of alternatives and options for the Ontario health system, the Premier's Council should be aware of those components that are now successfully operational in other jurisdictions. The success of these operations should be weighed against the issues and problems within the Ontario system and the needs of the Ontario society, to determine the efficacy of implementation in Ontario. One must not assume, however, that what "works" in another country would work equally well here in Ontario: health funding systems, by their very nature have a pronounced "cultural content."

E. WHAT ARE THE ALTERNATIVES?

1. Three key areas

As a result of our review, we have identified three high-priority areas that require attention from the Premier's Council on Health Strategy. These are:

- the myriad of linkages between providers and the provincial government
- physician funding
- hospital funding (operating and capital).

Other areas of concern are research funding, source of funds, prevention and promotion, consumer choice, and community care funding. Our analysis of these issues is set out in detail in Chapter VII — we summarize below the key alternative funding and incentive mechanisms for this area.

2. What are the alternatives for linkages to Queen's Park?

A key feature of current organizational linkages in the health system is the enormous number of hospitals, agencies and other providers that have direct linkages with the provincial government. The integration of the constituent elements of the health care system takes place at Queen's Park, an organizational level far removed from the delivery or consumption of the services the provincial government finances.

Decentralization

The management of health systems around the world is becoming increasingly decentralized. Service delivery models are emphasizing vertical and horizontal integration of services, focused on specific client groups in one-stop access programs. Strong arguments can be made for decentralized management through regional organizations that would facilitate integration and avoid duplication.

Several options are available to policy makers wishing to increase local control over resource allocation decisions and improve service integration. One option is the establishment of Local Health Agencies (LHA), an organizational arrangement common to a number of European countries and being developed in New Zealand. LHA's could be the funding and planning agencies for both institutional and community-based

programs. This organizational arrangement is not the addition of a bureaucratic tier between central government and providers, but more a delegation of responsibilities, particularly local resource allocation.

Integration

Another option is the establishment of Comprehensive Health Organizations (CHO), a service delivery model currently being tested by the Ministry of Health. In many communities, hospitals are the focal point of health delivery. Hospitals have the management depth that would allow them to manage a broader portfolio of local services. The integration of community-based and institutionalized health care into one management unit would facilitate service integration and reduce inter-agency competition through Queen's Park for limited resources. A variation of the CHO would be to broaden the sphere of responsibilities of selected hospital boards and with it the role of the hospital. Or, District Health Council's might be reconstituted with a more operational role.

3. What are the alternatives in physician funding?

Throughout the world physicians are paid in three major ways. These are:

- fee-for-service
- capitation
- salary.

Within these major categories a number of physicians are the key controllers in the health care system. Their payment mechanisms, therefore, must be structured to ensure that provincial health policies are met. Each payment mechanism has some features that are consistent with provincial objectives. However, each payment mechanism also has features that are at variance with provincial goals and need to be modified.

For example, fee-for-service mechanisms reward productivity but would have to be modified to encourage, say, prevention and health promotion. Capitation payments encourage de-institutionalization but may restrict people's access to doctor's services. Salaries provide effective financial control but do not ensure productivity. Maintenance of a high quality of care must go hand in hand with incentives. Quality of care goes beyond the quality of a specific clinical intervention. It must also ensure that the most appropriate intervention takes place. More care is not always synonomous with better care. Merit awards, administered by peer group reviews, are an option to consider in the quality assurance process.

It is not necessary to have one particular system for all physicians, in all parts of the province. A mixed compensation system might be developed that would bring together the needs of both physicians and government. There could be separate systems for academic physicians, family practitioners or specialists. There could also be specific mechanisms for paying physicians in different geographic areas and urban environments. Regardless of the system selected, the incentives have to be based on the goals that the province wishes to achieve.

4. What are the alternatives for hospitals?

Operations funding

Since 1969 Ontario hospitals have been funded primarily on a global budgeting system. Hospital expenditures have been relatively stable in real dollar terms compared to GPP. The global budgeting system is relatively simple to manage and provides effective cost control. However, hospitals argue that significant inequity has developed between the funding levels of various hospitals. There is a discordancy between the methods of funding hospitals and of physicians. We need to develop incentives that promote the movement away from the present heavy emphasis on institutional care.

Within the industry a number of alternative payment systems are available for hospitals:

- An itemized payment of service — under this system hospitals are reimbursed for each and every service provided. This system tends to be administratively complex and does not provide effective cost control. However, it does provide detailed information on services provided to the patient.

- Daily charges — under this system, hospitals are reimbursed for each day of care given to patients in the hospital. The system is somewhat simpler than itemized service payments as it does not require a detailed information bank on services provided to patients. This system provides incentives for controlling per diem rates. However, daily charges embody no inherent incentives to improve utilization and reduce length of stay.
- Case payment — under this system, hospitals are reimbursed for each admission. The admissions are weighted by case complexity. This system provides direct incentives to control both per diem costs and utilization for patients admitted to the hospital. However, there is little control on the level of hospitalization of patients and it does not cap total expenditures.
- Capitation — under this system, the hospital is prepaid a capitation rate for each resident within a service area. This system has incentives for controlling costs, utilization, and hospital admission rates. It may, however, restrict consumer access to service. The administration of a capitation system might require linkages with HSO's or CHO's to be effective.

Policy makers are faced with a dilemma. On the one hand, if productivity and consumer access is to be encouraged, fee-for-service mechanisms are appropriate. But without additional controls, the arrangement has proven to be very costly. On the other hand if real cost control is to be achieved the capitation system is appropriate, provided mechanisms to ensure consumer access to the services are in place.

The hospital funding system for Ontario can be modified by moving from the present global funding system and implementing one or a combination of the payment mechanisms described above. Alternatively the global budget system can be maintained and adjusted on an annual basis. If the global funding system is maintained, present inequities in the system need to be corrected. This could be done by providing all marginal annual rate increases at the peer group mean and/or giving priority to new program developments in lower-cost hospitals.

Ontario stands out in its reliance on institutional care. A major challenge is to find ways to reduce this dependence and to develop community-based services. As well, reimbursement techniques for hospitals should provide incentives to move people from institutional care to less costly community-based programs.

Capital funding

Hospitals have voiced a need for more money for capital redevelopment than the government can afford to supply. In addition, in the life cycle of a hospital, capital construction costs may represent only 2% of the overall health care costs. In other words, the operating costs associated with redeveloped hospitals are very significant.

In 1986 the Ontario government committed $850 million for the development of 4000 additional beds. We understand that the cost of these commitments has escalated to perhaps double the original estimate. At the same time, developments have taken place in the health care field that increase the emphasis on ambulatory and community-based programs, reducing the need for institutional care.

Many hospital accommodation studies indicate that about 10% of acute care beds and 25% of chronic care beds are occupied by patients who should be placed elsewhere. Many patients are placed inappropriately in high cost facilities whereas their true needs are for less intensive care. In the United States the dependency on acute care beds is approximately 25% lower than in Ontario. We believe that the plans to add additional acute and chronic beds to the system should be delayed until such time as the true bed needs of the province are established. There could be significant cost savings as the operating and capital costs for extended care facilities are significantly lower than for chronic or acute care beds.

However, some capital investments cannot be postponed. For example, developments that ensure fire codes are met, and potential future hazards are avoided, must continue. Also, capital developments that can reduce operating costs should be considered immediately. A priority system for capital investments should be developed to assist in the approval of capital expenditures.

5. What are the other funding issues?

We have described the major areas for funding and incentives that should be considered by the Premier's Council. However, a number of other areas also deserve consideration:

Research funding

In Ontario we spend less than 1% of our health care costs on research. The United States spends more than 2%. The health care system in Ontario will be faced with many serious choices in the foreseeable future. Policy formulation, decision making and alternative program selection must be well researched with objective data. Funds for new programs are limited and competition is intense for new money. We must ensure that the implications of new programs are thoroughly researched and understood before implementation. A number of areas require further research. These include:

- the cost impact of community care
- the cost impact of new technology
- the overall bed requirements for the province
- the development of outcome measures for the system
- the impact on quality of care of different methods of funding
- the development of public education programs to enhance patient choice
- the viability of prevention and promotion programs and the cost impact to society.

Sources of funds

This report deals mainly with the methods to dispense funds within the health system to provide and maintain a high level of quality service in a cost effective manner. The attempt is to manage the growth and redistribute the funding in the most cost-effective manner. Once this redistribution has been completed, we will be in a better position to determine whether more funding is required or whether a redistribution of the source of funds should be considered. Some of the choices might include:

- chronic co-payment charges to all chronic patients regardless of their present placement
- restriction of Ontario Health Insurance premium assistance and drug benefits to those who truly cannot afford to pay
- allowing controlled development of private hospitals as in the United Kingdom, New Zealand and the United States
- charges to consumers e.g., for "hotel" services, alternate choice meals, etc.
- a full-cost insurance system for health care coverage.

Prevention and promotion

Disease prevention and health promotion have evolved into two distinct concepts.

Disease prevention can be categorized as primary, secondary, or tertiary. The purpose of primary prevention is to prevent the occurance of disease through the identification and modification of risk factors. Primary preventive health services encompass interventions such as immunization, counselling, and family planning. The purpose of secondary prevention is to detect and treat disease early so that the patient is cured or the disease progression is slowed and/or complications prevented. Secondary preventive services include interventions such as screening programs. Tertiary prevention is often seen as disease treatment and rehabilitation aimed at limiting disability or restoring functions.

In the early days, health promotion was seen as something that promoted and encouraged people to adopt healthy lifestyles, which then meant observing good nutrition and personal hygiene and being physically fit. In recent years, health promotion has come to be defined much

more comprehensively. The World Health Organizaiton's definition is:

> *"health promotion is the process of enabling people to increase control over, and to improve, their health. It represents a mediating strategy between people and their environment, synthesizing personal choice and social responsibility in health to create a healthier future."*

Inequities in health opportunities are a major issue in health promotion. Despite the many advances of our health care system, people's health remains directly related to their economic status. The challenge we face is to reduce inequities in the health status of low income groups.

A substantial amount of work has already been completed in terms of reviewing health prevention and promotion in Ontario. However, further research is required to determine the efficacy of prevention and promotion initiatives.

Consumer choice

The monopolistic provision of health by the government, while providing universal access to patients regardless of income, is inherently restrictive. The virtual absence of a private sector in Canada provides no alternatives for consumers. Health care workers have little choice other than working for government-funded organizations. Most European countries have some private sector provision of health care and even in state-funded systems such as the UK's National Health Service, private-sector options are available to the consumer.

Consumer choice is further restricted by funding and resource allocation methods. For example, consumers cannot choose to use their health care tax dollars to purchase home care services that might avoid hospitalization. The choice is made for them by health care professionals during the resource allocation process. One mechanism for increasing consumer choice is a voucher system that would entitle holders to purchase services from their preferred providers. The flow of increased private sector funds into the health sector would also stimulate competition, and work towards ensuring that service provision reflects consumer demand.

Community-based programs

Our health care delivery is too institutional. We should be directing more funds to community-based programs. The amount of funding allocated by the Ministry of Health to community programs is about 5% of its total funds. However, this percentage does not include the community-based care provided by physicians or the ambulatory care program delivered by hospitals.

Throughout this report we have identified mechanisms to move toward community care. Organizational changes, and changes in funding physicians and hospitals, are required to reduce our dependency on institutional care.

F. PRINCIPLES GOVERNING A FUNDING SYSTEM

The reactive, as opposed to proactive, history of Ontario health care funding has obscured the essentiality of key principles governing important issues such as equity, quality, cost and freedom of consumer choice.

The funding system in Ontario, as in many other jurisdictions, has developed through a series of ad hoc arrangements. As a result, our present situation exhibits inconsistencies and anomalies. For example, the fee-for-service, open-ended nature of payments to physicians under the Ontario Health Insurance Plan and the Global Funding System of hospitals have inherent contradictions. The various methods of funding capital costs are inconsistent — and hard to rationalize since they do not always emphasize the shape of the health care system that the government and others wish to have.

Changes to the health care system can be facilitated by two major tools. The first tool is through changes in legislation or regulations. In this way providers and consumers can be mandated to perform in a certain way. The preferred tool is to adjust funding and incentives to move the system in the appropriate direction. This report deals with changes through this mechanism.

This study is an opportunity for the Premier's Council on Health Strategy to reassess the present funding systems and to recommend changes to better meet the needs of Ontarians. Paramount in all of this is the need to ensure that high quality care is provided. The funding system alone cannot do this. However, without the appropriate incentives and funding arrangements we may not be able to preserve existing quality without massive increases in funding (and also taxation). The government alone can make such decisions. However, we sense that cost increases of the magnitude we have projected could seriously distort priorities within our society without commensurate improvements in the health of our population.

Decisions about funding of the various components of the health care sector should not be made in isolation from each other. The interdependencies of the system have to be recognized. And the thrust towards services outside institutions must be reflected in funding arrangements and incentives that make sense to all concerned.

One consequence may well be the development of different organizational structures and linkages. We see merit in allowing for local differences, if this can be accommodated within overall government guidelines and funding policies. A diversity of organizational structures and linkages at a local or regional level can be a strength. Hopefully, a number of such pilot projects can be arranged over the next few years.

From a funding perspective, therefore, we believe that there could be advantages in having local choice about how specific components of the system are put together. However, this should be accomplished within a framework of an overall funding system that ensures equity and balance across the province as a whole.

The provincial funding system should therefore embrace the following six principles:

1. Equity

The system should ensure equity in funding and service levels across the province. In other words, a resident of northern Ontario is as entitled to health care services as a resident of Toronto. However, one cannot reasonably expect that all of the health care services presently available in Toronto should be available everywhere in the province. But the funding system should certainly permit the individual from northern Ontario to freely access the services required for optimal health care without geographic location being a limiting factor.

We have pointed out a number of ways in which equity can be ensured — for example through an allocation of funds on a capitation basis to some local organization such as a health service organization, a comprehensive health organization, or a local health agency.

2. Quality

The second major goal in the health care system is the maintenance or improvement of quality. "Quality" has broad implications. We have very few objective measures of it. In many cases, it is the cumulative judgement of the professional within the system that ensures that change has a positive impact and quality. Many of the alternatives suggested in this report have the potential of adjusting quality. Within some forms of funding, patient access is enhanced and quality should be enhanced as well. However, it can be argued that incentives that ensure easy patient access have the potential for over-servicing of patients. Over-servicing can have as many negative impacts on quality of care as under-servicing. With some forms of funding, the incentives are to reduce the patient contact with the system. We must be very careful that this apparently positive incentive from a cost perspective does not result in under-servicing of patients in need.

Quality of care is one of the successes in health systems. Ontario probably meets this test as well as any other jurisdiction in the world. So the cost pressures that urge reforms on us require a skillfully modulated response.

3. Harmonization of funding systems

The various compents of the health care sector should be harmoniously funded. In other words, the rules for funding one component of the system should not be at odds with those for funding other, related parts for the system.

4. Balance

There must be a balance in the money allocated to various components of the system. Currently we over emphasize inpatient care and have not fully developed ambulatory and community programs.

Many hospitals are already running community-based programs and this role could be expanded. However, we are conscious of the concern that many community groups have over the power and "hospital-based" focus of some of these programs.

As we mentioned earlier, precise organizational arrangements at the local level should not be copied from a template decreed by Queen's Park. Equally, given the availability of overall provincial guidelines, the ministry should be able to count on local people to ensure that the high quality care they expect is provided in the most appropriate way for their community.

5. Incentives

We clearly need to develop incentives for cost control. In the example quoted above, many hospitals would be more than ready to rechannel their resources to help provide ambulatory and community care services if they had the incentive to do so. Equally, we could visualize cooperative arrangements between commuity-based groups, hospitals and physicians in whatever organizational structure or linkages make most sense to them.

Incentives should be designed to achieve the overall goal of the system — which currently we perceive to be directed towards the development of non-institutionally based services, and synchronization of activities amongst the various players in the system.

Incentives should not only be in place for organizations. Within organizations themselves, certain incentives might also be considered to harness the energies and drive of people at various levels in the system. Incentives to consumers should also be considered.

6. Choice

Choice is important. We want to avoid a rigid, structured system that would de-personalize the care we now receive. At the same time, we cannot set the existing system in concrete and regard it as unchangeable. What seems to be important is to allow consumers to have choice over how they will receive services and how they will pay for them. Certainly we should not forget the providers of health care services. They should be stimulated to look at new ways of providing health care and also, we believe, alternative ways in which they may be fairly compensated for the services they provide.

Other key principles may be developed as discussions continue about the restructuring of the way in which the health care system is funded. However, an integrated application of the six principles noted above would go a long way towards helping those who must design a new system to ensure that it meets the changing needs of our society.

APPENDIX 3: COMMUNITY SERVICES STUDY

SUMMARY AND IMPLEMENTATION FRAMEWORK
Prepared for the Premier's Council on Health Strategy
by Price Waterhouse

COMMUNITY SERVICES STUDY

EXECUTIVE SUMMARY

Much attention has been given to the importance of strengthening community services in the Ontario health care system. A succession of reports over the last few decades has contained recommendations to enhance the role of services provided in the community. However, many of these recommendations have not yet been translated into action.

The Health Care System Committee of the Premier's Council on Health Strategy commissioned this study with a view to identifying strategies to achieve progress toward a stronger community services sector. It was the view of the Committee that the principle challenge is not so much to develop new proposals for delivering community services but to understand why past recommendations have not been implemented and to identify strategies to ensure whole hearted implementation of such recommendations for the future. This study, therefore, set out to accomplish the following:

- review previous recommendations for enhancing community services;
- examine issues and problems that contribute to the rationale for community services;
- develop a vision for community services;
- identify obstacles to achieving the vision;
- identify positive factors that could be harnessed to help achieve the vision;
- recommend initiatives;
- provide an implementation framework.

In conducting this study, the consultants interviewed many spokespersons and commentators on health care in the province, prepared a preliminary discussion paper and held an expert panel conference to review the discussion paper.

DEFINITION OF COMMUNITY SERVICES

For this study, we adopted a definition of community services that sees community services as services that are defined primarily in terms of their focus, locale, accountability and who provides the services:

- the *focus* is on individual independence, local health needs, and the achievement of direct impacts on health;
- the *locale* for the provision of services is the home or the local community;
- *accountability* for planning, management and results for the services lie with the local community and those who provide the services;
- the *providers* of services include health professionals, non-professionals and volunteers.

RATIONALE

We reviewed the rationale for emphasizing community services offered by previous reports. Common themes included:

- concerns about costs of care and the future cost impacts of projected demographic change and changing patterns of illness;
- concerns about an over emphasis on treatment rather that prevention, promotion and maintenance;
- concerns about fragmentation and lack of co-ordination;
- belief that community services are more responsive to individual and community needs and to the needs of "special" and disadvantaged groups; and
- desirability of non-institutional care compared to institutional care.

There was a high degree of congruence between the rationales for community services offered in previous reports, and those we heard from members of Premier's Council Health Care System Committee and the participants in the expert panel conference. This was interpreted as confirming the fundamental soundness of directions articulated in previous reports.

ISSUES AND PROBLEMS

The study identified shortcomings of the existing system and anticipated pressures that provide further impetus for seeking to strengthen community services. These included:

- imbalances in the existing health care system;
- adverse impacts of demographic change;
- changing patterns of illness;
- need to spread the responsibility for health and health care;
- discrepancies between health and social

service models;
- rigidity of funding programs;
- secondary status of community services; and
- unrealistic expectations of community services.

COMMUNITY COSTS COMPARED TO INSTITUTIONAL COSTS

It is often argued that community services represent a less costly alternative to institutional care. After examining this question closely we concluded:

- it is too simplistic to think of community services primarily as a cost-effective alternative to institutional services. In some cases they are, in some cases they may be, and in others they are not comparable;
- there is only a partial congruence between community service populations and institutional service populations. For many types of community services, their purpose does not involve serving groups who would otherwise be in institutions;
- where there is some degree of overlap between community and institutional services (such as long-term care), a narrow approach that focuses exclusively on the role of community services as a cost-effective alternative may ignore other important considerations, including quality of life, flexibility, client independence, family burden and fundamental preference.

VISION

We propose a vision for a strong, responsive and effective community services sector, one comprising services with the following characteristics:

- services which respond to the unique needs of the community they serve;
- services which set out to help individuals live with the greatest possible degree of independence in their own communities;
- services which are accountable to the community and are not externally controlled; and
- services which are delivered in a manner that empowers communities and individual consumers.

We identified four key values that should be reflected in the community services sector:

- dignity;
- choice;
- equity; and
- cost-effectiveness

In achieving this broad vision, three major directions are proposed:

i) to enhance the responsiveness, accountability and effectiveness of community services by:
   - expanding the scope of community services with greater emphasis on promotion, prevention and health maintenance;
   - achieving more flexible program funding and delivery methods;
   - vesting greater power and responsibility in the community sector; and
   - achieving broader use of and participation in community services.

ii) to achieve recognition that the community services sector can make a contribution to health that is at least as significant as that of the institutional sector.

iii) to make the institutional sector more responsive to the community sector and to community needs.

OBSTACLES

The study noted several obstacles that have contributed to the failure to fully implement the recommendations of previous reports:

- public complacency regarding the need for change in the health care system;
- inadequate attention to community services in professional education;
- lack of awareness of community services;
- treatment of community services as an "add on";
- lack of implementation savvy; and
- pressure for hospitals to assume more specialized roles, diminishing their broader general community roles.

FACILITATING FACTORS

On the more positive side, we also identified several aspects of the current environment that offer opportunities for achieving change:

- establishment of the Premier's Council on Health Strategy;
- expression of political will;
- imperatives of the fiscal environment;
- recognition of the need to anticipate growing demand for health care;
- new organization of the Ministry of Health; and
- Management Board's Review of the Health and Social Service Program Structure.

RECOMMENDED INITIATIVES

The study proposed policy and programmatic initiatives that would help to realize the three directions emerging from the vision and address obstacles to implementation. Within each initiative, numerous actionable proposals were also put forward.

Recommended initiatives for the organization of services were:

- rationalization and local planning of community services;
- partnerships and collaboration;
- enhancing access to community services; and
- encouraging new sponsors for community services.

Recommended initiatives for funding were:

- integration of funding streams;
- more secure funding of community services; and
- local funding envelopes.

Recommended initiatives for training and manpower were:

- creation of attractive professional career opportunities in community services;
- joint professional/government manpower planning;
- requirements to educate health professionals to practise in community settings.

Recommended information and support building initiatives were:

- marketing and information on community services;
- heightening public awareness of current and impending problems in the province's health care delivery;
- fostering development of a strong, organized voice for community services; and
- support for community services research and evaluative studies.

IMPLEMENTATION FRAMEWORK

Finally, the study proposed an implementation framework to ensure well defined accountability structures and processes for implementation. It was recommended that the Premier's Council establish a Community Services Implementation Secretariat to assume responsibility for overseeing the implementation process. This would include coordinating and monitoring implementation of recommended initiatives.

IMPLEMENTATION FRAMEWORK

Implementation is the Achilles heel of realizing the vision for a stronger, more responsive and effective community services sector. We attribute the failure of past recommendations, in large part, to shortcomings in implementation. In this context, we recommend well-defined accountability structures and processes for implementation.

We recommend the establishment by the Premier's Council of a Community Services Implementation Secretariat. This body would be charged with overseeing the implementation of the initiatives and actionable proposals put forward in this report. It would develop detailed implementation plans for each actionable proposal in consultation with the ministries and other agencies responsible for their implementation. It would coordinate and monitor implementation, and report implementation progress to Council on a twice yearly basis. It would sponsor evaluation studies jointly with the groups responsible for specific initiatives/actionable proposals. All the actionable proposals put forward in this report should be subject to evaluation as part of the implementation process. Evaluation results should be reported to Council.

We recognize that the directions outlined in this study represent a substantial shift for the province's health care system. Clearly, their implementation has to be planned carefully. This will include assessment of impacts and implications for other providers and for consumers; consultation with agencies responsible for providing services; information on and promotion of new initiatives; linkages with other services; and articulating and communicating objectives to the public, service providers and community agencies.

APPENDIX 4: PARTICIPANTS IN THE EXPERT PANEL CONFERENCE

PREMIER'S COUNCIL MEMBERS AND STAFF

Mr. Roy Aitken
Executive Vice-President, Inco.
Chair, Health Care System Committee
Premier's Council on Health Strategy

Mr. John Carter
President, Greater Niagara General Hospital
Member, Health Care System Committee
Premier's Council on Health Strategy

Ms. Eleanor Ross
President, Registered Nurses Association of Ontario
Member, Health Care System Committee
Premier's Council on Health Strategy

Dr. Hugh Scully
Past President, Ontario Medical Association
Cardiovascular Surgeon, Toronto General Hospital
Member, Health Care System Committee
Premier's Council on Health Strategy

Dr. Reva Gerstein, O.C.
Psychologist
Vice Chair, Board of Trustees, Hospital for Sick Children
Chair, Healthy Public Policy Committee
Premier's Council on Health Strategy

Ms. Mary Shamley
Past Chair, Association of District Health Councils
Chair, Thames Valley District Health Council
Chair, Health Goals Committee
Premier's Council on Health Strategy

Dr. Naomi Rae-Grant
Psychiatrist, Child and Adolescent Services, Victoria Hospital, London, Ontario
Member, Integration and Coordination Committee
Premier's Council on Health Strategy

Dr. Martin Barkin
Deputy Minister of Health
Past President, Sunnybrook Medical Centre
Secretary, Premier's Council on Health Strategy

Ms. Marilyn Knox
Executive Director
Premier's Council on Health Strategy

Mr. Lorne Zon
Manager, Health Innovations
Premier's Council on Health Strategy

Ms. Terry Bisset
Manager, Internal Relations
Premier's Council on Health Strategy

Dr. Jim Shosenberg
Manager, External Relations/Communications
Premier's Council on Health Strategy

INVITED ATTENDEES

Ms. Jennifer Ritchie
Consumer
Toronto, Ontario

Mr. Peter Ellis
President, Sunnybrook Medical Centre
North York, Ontario

Ms. Brenda Singer
Executive Director, Progress Place
Toronto, Ontario

Mr. John Butler
Executive Director, Peel District Health Council
Brampton, Ontario

Mr. Graham Scott
Former Deputy Minister of Health
Partner, McMillan and Binch
Chair, Task Force on the Use and Provision of Medical Services

Mr. Ron Draper
Office of Health Education
World Health Organization
European Regional Officer
Copenhagen, Denmark

Mr. W. Vickery Stoughton
President, The Toronto Hospital
Toronto, Ontario

Dr. Abbyann Lynch
Director, Westminister Institute for Ethics and Human Values
London, Ontario

Dr. Sandy MacPherson
Education Centre for Aging
Hamilton, Ontario

Dr. Nancy Milio
Professor, University of North Carolina
Chapel Hill, North Carolina

Mr. James Callahan
Professor, Heller School
Brandeis University
Waltham, Massachusetts

Ms. Maya Kagis
President, Ontario Association of Health Centres

GOVERNMENT OFFICIALS

Mr. Mike McEwen
Area Planning Coordinator - District Health Council Program
Ministry Liaison, Health Care System Committee

Mr. Jay Kaufman
Assistant Deputy Minister
Institutional Health
Ministry of Health

Mr. Terry Hewak
Senior Economist
Fiscal Planning Policy Branch
Ministry of Treasury and Economics

Mr. Michael Mendelson
Assistant Deputy Minister
Community Services Division
Ministry of Community and Social Services

Dr. Robert MacMillan
Assistant Deputy Minister
Community Health
Ministry of Health

ALBERTA DELEGATION

Dr. Alex McPherson
Oncologist
Deputy Commissioner, Premier's Commission on Future Health Care for Albertans

Mr. Gene Murrant
Electrical Contractor
Commissioner, Premier's Commission on Future Health Care for Albertans

Dr. Ruth Collins-Nakai
Pediatric Cardiologist
Commissioner, Premier's Commission on Future Health Care for Albertans

Ms. Carol Snedden
Commissioner, Premier's Commission on Future Health Care for Albertans

CONSULTANTS

Mr. Neil Stuart
Price Waterhouse

Ms. Debbie Leach
Price Waterhouse

Mr. Jim Stonehouse
Price Waterhouse

Ms. Siobhan Cavanaugh
Price Waterhouse

Mr. Bill Bain
Stevenson Kellogg Ernst & Whinney

Mr. Ted Gillespie
Stevenson Kellogg Ernst & Whinney

Mr. Tony Culyer
Stevenson Kellogg Ernst & Whinney

Mr. Rowland Hope
Stevenson Kellogg Ernst & Whinney

Dr. Alan Raisbeck
Stevenson Kellogg Ernst & Whinney

Dr. Geoffrey Anderson
Stevenson Kellogg Ernst & Whinney

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